# Review of CSB Child & Adolescent Services

Presented to
Joint Commission on Health Care
Behavioral Health Subcommittee

James W. Stewart, III - Inspector General
Mental Health, Mental Retardation
& Substance Abuse Services
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## Phases I/II – CSB Survey/Site Visits

- Survey of all 40 CSBs - Nov 2007
  - Services provided & structure
  - Staffing & budget
  - Factors that encourage/hinder development of services
- Site visits to 34 CSBs - March/April 2008
  - Interviewed 175 family members/guardians
  - Reviewed 469 case records
  - Interviewed over 1000 CSB direct service staff & supervisors

# Phase III – Survey of Stakeholders

- Invited 1,500 CSA CPMT and FAPT members to respond – DSS, Schools, Juvenile Justice, Health, family members
- 520 completed the survey
- Questions survey focused on:
  - Views of CSB as MH provider & as CSA partner
  - Community service needs and gaps
  - Priority services to reduce/prevent residential placements



# Number C/A Served Statewide FY2007 - All Disabilities

| | MH | SA | ID | Total |
|---|---|---|---|---|
| **Number Served** | 29,357 | 7,841 | 4,891 | 42,089 |
| **% of VA 0-17 Population 1,863,274** | 1.6% | .5% | .3% | 2.2% |

## Total C/A Budget Statewide FY2007 All Disabilities (In Millions)

| | MH | SA | ID | Total |
|---|---|---|---|---|
| **Budget** | $91.07 | $14.99 | $12.96 | $119.02 |
| **% by Disability** | 76.5% | 12.6% | 10.9% | |



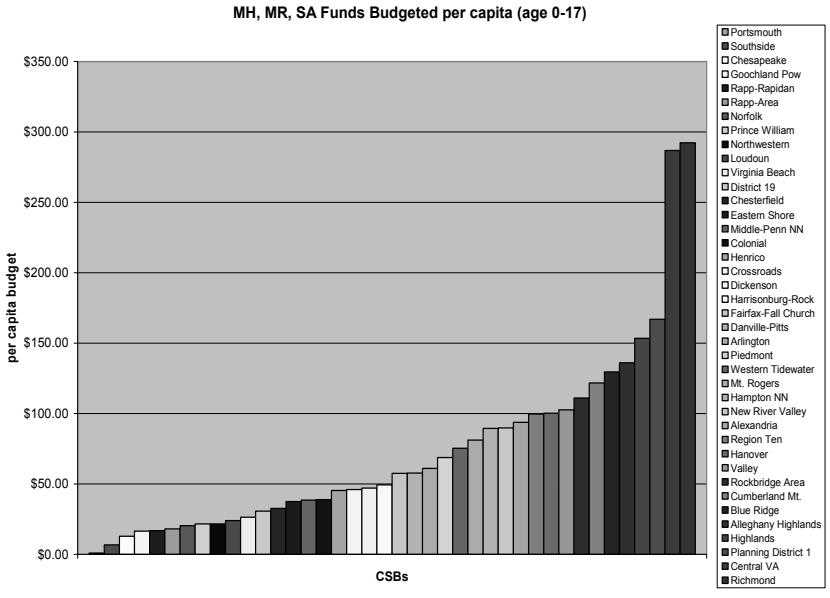
## Finding – Wide Variation in Service Availability

Families seeking services for children and adolescents with MH, SA or ID service needs face enormous differences in service availability depending on where they live. Whether measured by expenditures, staffing, or percentage of child population served, the availability of services for children and adolescents offered by CSBs varies widely among communities.

# Total C/A Budgeted/Capita by CSB
# 2007 - All Disabilities

| Highest 5 CSBs | | Lowest 5 CSBs | |
|---|---|---|---|
| 1 Richmond | $292.30 | 36 Rapp-Rap | $16.80 |
| 2 Central VA | $286.84 | 37 Goo Pow | $16.52 |
| 3 PD 1 | $166.90 | 38 Chesapeake | $12.88 |
| 4 Highlands | $153.36 | 39 Southside | $6.72 |
| 5 Allega High | $136.05 | 40 Portsmouth | $0.96 |
| Midpoint - $53.45 | | | |





# Funding for MH Services

- MH budgets range from $25,000 to $12,821,615
- Per capita MH funding based on child population in catchment area:
  - Highest $258.36 per child
  - Lowest $0.96 per child
  - Average $58.01 per child
  - Median $37.26 per child



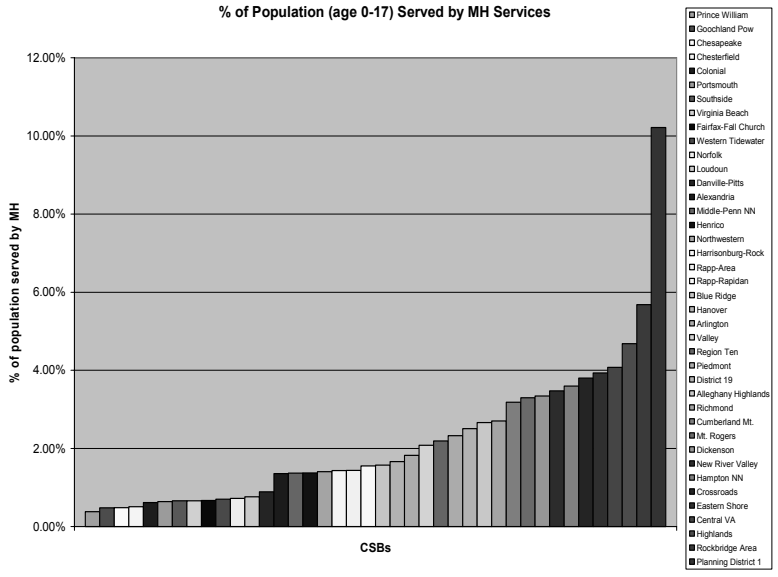
# Staffing for MH Services

- 1,342 FTE staff in MH statewide
- Ranges from 1.5 to 223 staff per CSB
- Staff to community population ratios:
  - Highest 1 to 237 child population
  - Lowest 1 to 15,380 child population
  - Average 1 to 3,038 child population
  - Median 1 to 1,997 child population

# Number Served by MH Services

- Number served ranges from 48 to 3,094
- Service penetration in community:
  - Highest 10.21%
  - Lowest 0.38%
  - Average 2.2%
  - Median 1.6%

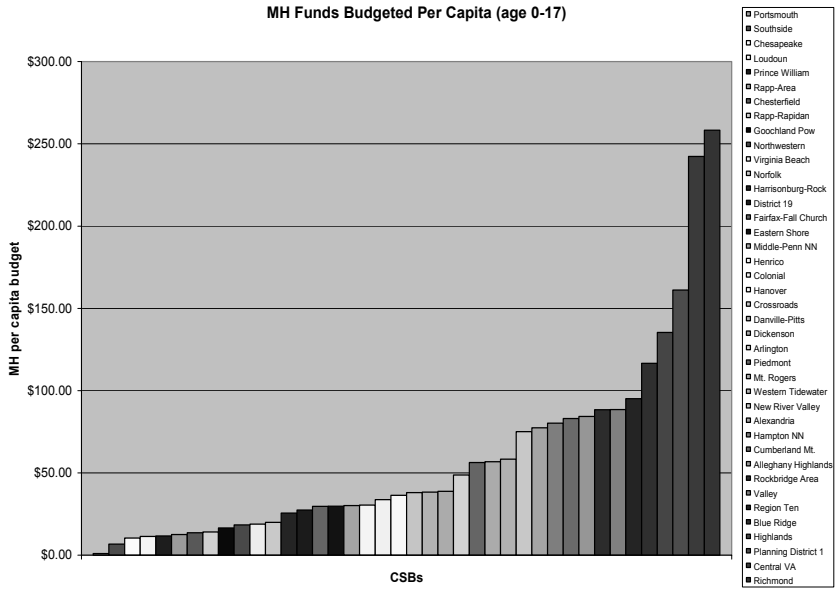




# Finding – Sources of Funding

State general funds and local funding make up a relatively small portion of total funds for child and adolescent services statewide. CSA funding to CSBs is also a limited source. CSBs that have developed the most extensive systems of services for children and adolescents have done so primarily through the use of Medicaid .





## MH Funding % by Source
## Six Highest Per Capita CSBs

| CSB | State | Local | MCD | CSA | Grants |
|---|---|---|---|---|---|
| 1 Richmond | 1.4 | 0 | 76.5 | 12.4 | 9.7 |
| 2 Central VA | 1.1 | 1.0 | 83.3 | 6.7 | 7.2 |
| 3 PD 1 | 2.0 | 0.8 | 62.7 | 0 | 29.9 |
| 4 Highlands | 5 | 2.6 | 51.1 | 37.2 | 4.1 |
| 5 Blue Ridge | 11.2 | 0.2 | 74.5 | 8.7 | 4.5 |
| 6 Region 10 | 6.6 | 0.4 | 82.4 | 5.3 | 5.3 |
| Ave - 6 CSBs | 4.5 | .8 | 72 | 11.7 | 11.9 |

## Observations About Sources of Funding for C/A MH Services

- 48% CSBs - over 50% of funds from Medicaid
- 30% CSBs - 10% or less from Medicaid
- 72% CSBs –10% or less from CSA
- 40% CSBs – 10% or less from State GF
- 68% CSBs – 10% or less from local gov't

# Resulting Findings

- No CSB offers a complete array of C/A services with sufficient capacity to meet community needs.
- Many CSBs have very limited service systems and some provide only minimal levels of case mgt and emergency services.
- C/A services at CSBs are full to capacity, resulting on long waiting periods.
- Access to services for uninsured families is extremely limited.



# Findings – Service Quality

- Parents/caregivers of children receiving services at CSBs report very high levels of satisfaction.
- Family level of involvement with CSB staff planning & provision of services is quite high.
- Few CSBs offer nationally recognized "evidence-based practices"
- Identification and treatment of co-occurring SA & MH issues is less than optimal.

# Family Interviews

| | Agree | Disagree |
|---|---|---|
| Involved in treatm't planning | 88.6% | 8.6% |
| Satisfied with am't of time | 91.4% | 7.4% |
| Getting as much help as need | 85.2% | 14.8% |
| Child/family benefits fm srvs | 93.2% | 6.8% |
| Noticed improvement | 85.2% | 14.2% |
| Satisfied with services | 96% | 3.4% |



# Findings – CSA/Interagency Coordination

- While majority of community stakeholders rate CSB cooperativeness and communication favorably, a large minority provide negative ratings.
- CSBs are not the provider of choice for community-based CSA-funded MH services in many communities.

# Findings – CSA/Interagency Coordination

- Over half the CSBs have developed one or more specific services to help improve the provision of services offered to children in the CSA system.



# CSB Services in Support of CSA

- Intensive care coordination 18 (45%)
- Utilization management 14 (35%)
- Provide both services 10 (25%)
- Provide one or both services 22 (55%)

## Changes CSBs Think Would Improve CSA System

- Clearer, mandatory role for CSBs in assessing, leading planning & providing case mgt to children in CSA system
- Creation of added CSB services to meet needs of CSA children with state or CSA funds
- Increased oversight, UM for CSA expenditures
- Reduce CSA reliance on residential services & commitment to community-based services
- Expansion of eligibility for CSA services



## Findings – CSB Workforce

- CSBs have great difficulty recruiting and retaining qualified staff to provide children's services.
- CSBs have inadequate psychiatric time to meet the needs of the children in their communities. Only 12.5% of CSBs report adequate psychiatric resources. The average wait to see psychiatrist is 37 days. CSBs estimate that 25 FTE psychiatrists are needed statewide.

# Stakeholder Interviews - 520

| | |
|---|---|
| Social Services | 145 |
| Public Schools | 77 |
| Juvenile/Domestic Relations Court | 58 |
| Health Department | 34 |
| Private Provider | 47 |
| Family Member | 12 |
| Other | 147 |



# Stakeholder Survey

| | Agree | Disagree |
|---|---|---|
| I am usually satisfied with results of CSB services | 60.7% | 37.4% |
| CSB is usually provider of choice for FAPT/CPMT | 62.9% | 34.9% |
| CSB collaborates with my agency in planning for child | 64.8% | 31.1% |
| CSB is vigorous & effective partner in our local CSA | 62.6% | 35% |

# Stakeholder Survey

| | Agree | Disagree |
|---|---|---|
| CSB keeps me informed about progress of treatment | 48% | 37% |
| CSB involves families in assessment & planning | 78.3% | 10.9% |
| CSB MH services have good treatment outcomes | 57.3% | 35.3% |
| CSB emergency program is responsive, effective means to keep child in community | 52.2% | 43% |



# Stakeholder Survey

| | Agree | Disagree |
|---|---|---|
| I find that most of children I see with MH needs can be served by the CSB | 44% | 51% |
| CSB does good job of meeting needs of children with mental retardation | 54.9% | 27.9% |
| CSB does good job of meeting needs of children with substance abuse probs. | 39% | 42% |

# What does your CSB do well?

| |
|---|
| Cooperate, collaborate w/ agencies, improves system |
| Provides effective/excellent services |
| Leader/expert on MH issues in community |
| Provides specialized services to children w/ DD/ID |
| Targeting services to indigent children/families |
| Active partner in CSA processes |
| Substance abuse evaluations & treatment/prevention |



# What is your biggest criticism of the CSB?

| |
|---|
| Waiting list. Takes too long to start services. |
| Do not offer comprehensive range of needed services. |
| CSB is not collaborative with other agencies |
| CSB does not provide adequate SA services |
| Eligibility for services for those without Medicaid, insurance or CSA is very limited. |

## What service would help prevent residential placement out of community?

| |
|---|
| Home-based intensive services – wrap around srvs |
| Substance abuse outpatient services |
| Residential options in community |
| Mental health outpatient services |
| Broader range of assessment and evaluation services |
| Educational support and treatment for families/parents |
| Comm-based srvs for sexually acting-out children |



## Factors Most Help Development of CSB Child/Adol MH Services

- Community requests, needs, support for development of services
- Creation of CSA, support of partner agencies
- Creation & growth of Medicaid funding
- Leadership of our executive director & Child/Adolescent services director

## Factors Most Hindering Development of CSB Child/Adol MH Services

- Lack of funding flexibility
- Difficulty recruiting and retaining qualified child staff
- Transportation for families and staff
- Agency structure limits priority for children
- Difficulty finding and attracting psychiatrists



## What State Should do to Develop Child MH Services

- DMHMRSAS provide training
- Expand types of services eligible for reimbursement (Medicaid) – non-SED, at risk, prevention, non-mandated
- DMHMRSAS reflect priority in all areas/activities/policies
- Create mandate for local child MH services, school-based, etc.
- Assist communities with providing psychiatric services, work with communities

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